



*MaineCare Services*

*An Office of the  
Department of Health and Human Services*

*Paul R. LePage, Governor*

*Mary C. Mayhew, Commissioner*

# MDS-RCA Training

Case Mix Team

Office of MaineCare Services

April 2014



# MDS-RCA Training: Agenda

- History of MDS-RCA
- Purpose:
- Definitions
- Schedule of Assessments
- Case Mix Index, RUGs
- Accuracy and Sanctions
- MDS-RCA Assessment Tool
- Correction Policy
- Quality Indicators





In **1994** a workgroup made up of providers, Muskie School and DHHS representatives was established to provide recommendations for development of:

- MDS-RCA form design and content
- Classification system
- Case Mix payment system
- Quality Indicators



## 1995 Time Study

Twenty five facilities, with a total of 626 residents, participated in this time study. This included the following residents:

- In small facilities
- With head injuries
- With Alzheimer's Disease
- With Mental illness





## 1999 Time Study

Thirty-two Facilities, with a total of 735 residents, participated in another time study. Facilities were selected according to:

- Overall population
- Presence of complex residents
- Presence of residents with mental health issues
- Presence of residents with Alzheimer's or other Dementia
- Presence of elderly population





## 1999 Time Study Results



- Residents were more dependent in ADL's
- There was an increase in residents with Alzheimer's and other Dementias.
- There was an increase in wandering and intimidating behaviors.
- There was an increase in the amount of time needed to care for these residents
- The Case Mix Grouper needed to be revised



# **Who, What, Where, Why and, When... of Case Mix**



## So... Who completes the MDS-RCA?

...The **MDS-RCA Coordinator**  
with help from:

- ✓ The resident
- ✓ Personal Support Specialists
- ✓ CRMA
- ✓ family
- ✓ clinical records
- ✓ Social Services
- ✓ dietary, activities and other staff







## **And... What is Case Mix?**

**Case Mix is a system of reimbursement that pays facilities according to the amount of time spent providing care to residents.**

**Residents are grouped according to the amount of time needed to provide their care**





**And... Where is the assessment done?**

**MDS-RCA assessment is completed in the facility**

- **All residents**
- **Regardless of payer source**

**The MDS-RCA cannot be completed if the resident is not in the facility. For example, if in the hospital or on a therapeutic leave**





## **And... Why do we need to do MDS-RCA Assessments?**

- 1. To provide information to guide staff in developing a realistic individualized Service Plan.**
- 2. To place a resident into a payment group within the Case Mix System.**
- 3. To provide information that determines the Quality Indicators.**
- 4. To show an accurate picture of the resident's condition, the type and amount of care needed**





**So... Why do we need to do MDS-RCA Assessments? (cont.)**

- 5. Improve equity of payment to providers**
- 6. Provide incentives to facilities for accepting residents with higher care needs**
- 7. Strengthens the quality of care and quality of life for residents.**



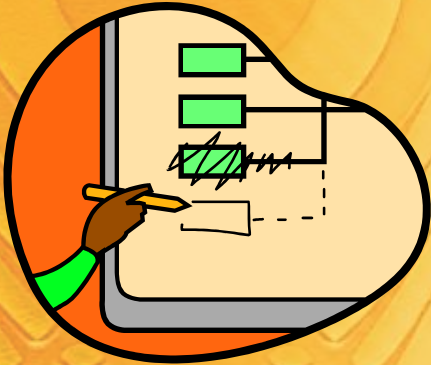
## Schedule of Assessments:

Type of Assessment	When Performed	When does it need to be completed
Admission Assessment	initial admission	By the end of 30 <sup>th</sup> day after admission as represented by S2b date; Admission date is counted as day one.
Semi-Annual Assessment	Within 180 days of the last MDS-RCA, sequenced from the S2b date of the previous assessment	Within 7 days of the assessment date entered in A5, as represented by S2b date
Annual Assessment	Within 12 months of the most recent MDS-RCA assessment	Within 7 days of Assessment date entered in A5 as represented by S2b date
Significant Change Assessment	Only if significant change has occurred	By 14 <sup>th</sup> day after change has occurred as represented by S2b date
Other	When requested by Case Mix Nurse. This will "reset" the clock for all subsequent assessments	Within 7 calendar days of Case Mix nurse visit as represented by S2b date
Discharge Tracking Form	When a resident is discharged, transferred or deceased	Within 7 days of the event
Basic Assessment Tracking Form Identification Information	Provides key information to uniquely identify each resident and to track the resident in an automated system	Complete with all assessments and discharges within 7 days of the event





## When to complete a Significant Change MDS-RCA assessment:



- Resident has experienced a “major change”
- Not self-limited
- Impacts more than one area of the resident’s clinical status
- Requires review and/or changes to the service plan
- Improvement or decline
- Completed by the end of the 14<sup>th</sup> day following the documented determination



## Timeliness

MaineCare Benefits Manual, Chapter III, Section 97, §7060.1:

“The Department will sanction providers for failure to complete assessments completely, accurately and on a timely basis.”





## Accuracy

Each assessment must be conducted or coordinated by staff *trained in the completion of the MDS-RCA*.

**Documentation is required to support the time periods and information coded on the MDS-RCA. (MBM, chapter III, Section 97, Appendix C, §7030.3)**

Penalty for Falsification: The provider may be sanctioned whenever an individual willfully and knowingly certifies (*or causes another individual to certify*) a material and false statement in a resident assessment.



## Case Mix Quality Assurance Review



About every 6 months, a Case Mix nurse reviews a number of MDS-RCA assessments and resident records to check the accuracy of the MDS-RCA assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS-RCA may lead to an error.



## Poor Documentation could mean...

Lower payment than the facility could be receiving, OR

Overpayment which could lead to repayment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.





## Sanctions:

**2%** of MaineCare payments when the assessment review results in an error rate of 34% or greater, but is less than 37%.

**5%** of MaineCare payments when the assessment review results in an error rate of 37% or greater, but is less than 41%.

**7%** of MaineCare payments when the assessment review results in an error rate of 41% or greater, but is less than 45%.



## Sanctions (cont.)

**10%** of MaineCare payments when the assessment review results in an error rate of 45% or greater.

**10%** of MaineCare payments if the provider fails to complete reassessments within 7 days of a written notice/request by the Department.



## Case Mix Resident Classification Groups and Weights

There are a total of **15** case mix classification or RUG (Resource Utilization Groups) groups, including one default group used when a resident cannot be classified into one of the other 14 classification groups.





## 5 categories:

- Impaired Cognition
- Clinically Complex
- Behavioral Health
- Physical
- Default or Not Classified

The Department assigns each case mix classification group a specific case mix weight, as follows...



**MAINECARE RCF RESOURCE GROUP WEIGHTS**

<b>Resident Group</b>	<b>Order</b>	<b>Short description</b>	<b>MaineCare Weight</b>
IC1	1	IMPAIRED 15-28	2.250
IB1	2	IMPAIRED 12-14	1.568
IA1	3	IMPAIRED 0-11	1.144
CD1	4	COMPLEX 12-28	1.944
CC1	5	COMPLEX 7-11	1.593
CB1	6	COMPLEX 2-6	1.205
CA1	7	COMPLEX 0-1	0.938
MC1	8	BEHAVIORAL HEALTH 16-28	1.916
MB1	9	BEHAVIORAL HEALTH 5-15	1.377
MA1	10	BEHAVIORAL HEALTH 0-4	0.980
PD1	11	PHYSICAL 11-28	1.418
PC1	12	PHYSICAL 8-10	1.019
PB1	13	PHYSICAL 4-7	1.004
PA1	14	PHYSICAL 0-3	0.731
BC1	15	NOT CLASSIFIED	0.731



## The ADL index score is determined as follows:

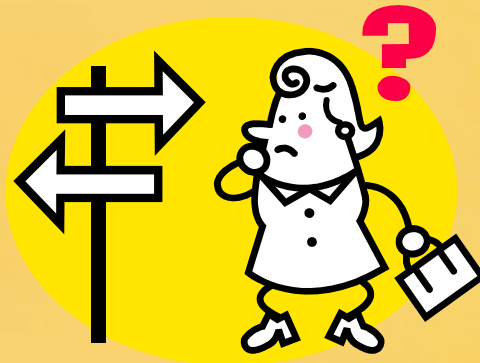
ADL Function	Self-Performance	MDS-RCA Code	ADL Score
1. Bed Mobility (G1aa)	Independent	0	0
2. Transfer (G1ba)	Supervision	1	1
3. Locomotion (G1ca)	Limited Assistance	2	2
4. Dressing (G1da)	Extensive assistance	3	3
5. Eating (G1ea)	Total Dependence	4	4
6. Toilet Use (G1fa)			
7. Personal Hygiene (G1ga)	Activity did not occur	8	4





## Impaired Cognition Groups

Impaired Cognition	B3=3: severely impaired daily decision-making	3	IA1	0-11	Impaired Cognition low ADL	1.144
		2	IB1	12-14	Impaired Cognition medium ADL	1.568
		1	IC1	15-28	Impaired Cognition high ADL	2.25





## Clinically Complex Groups

Clinically Complex	At least one of the following conditions:	9	CA1	0-1	Complex low ADL	0.938
	I1a=1: diabetics receiving daily injections					
	I1r: aphasia					
	I1s: cerebral palsy					
	I1v: hemiparesis/hemiplegia					
	I1w: MS					
	I1z: quadriplegia					
	I1ww: explicit terminal prognosis					
	M1b: burns					
	M2a,b,c or d (coded >0): ulcers due to pressure or decreased blood flow					
	O4ag=7: diabetics receiving daily injections					
	P1aa: radiation / chemotherapy					
	P1ab: oxygen					
	P1bda>5: respiratory therapy 5 or more days per week					
Clinically Complex	P3a=1, 2, or 3: monitoring for acute conditions	10	CB1	2-6	Complex medium ADL	1.205
	P3b=1, 2, or 3: monitoring for acute conditions	11	CC1	7-11	Complex high ADL	1.593
	P10>3 meaning 4 or more <u>days</u> with physician order changes	12	CD1	12-28	Complex very-high ADL	1.944





## Behavioral Health Groups

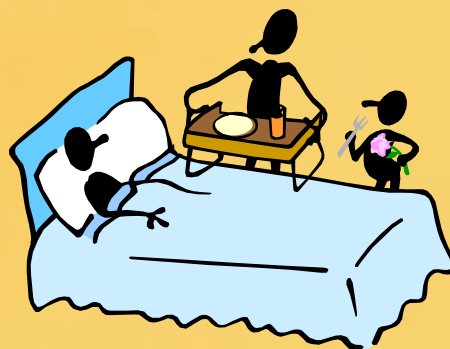
Behavioral Health	E1a-E1r: two or more indicators of depression, anxiety or sad mood (coded as 1 or 2), OR	6	MA1	0-4	Behavior Health low ADL	0.98
	P2a-p2j: three or more items checked. Three or more interventions or programs for mood, behavior, or cognitive loss, OR					
	J1e: delusions, OR					
	J1f: hallucinations	7	MB1	5-15	Behavior Health medium ADL	1.377
		8	MC1	16-28	Behavior Health high ADL	1.916





## Physical and Default groups

Not Classified	MDS-RCA RUG items contain invalid or missing data	1	BC1	n/a	Default	0.731
Physical	No additional items, assistance with ADL only	2	PA1	0-3	Physical low ADL	0.731
		3	PB1	4-7	Physical medium ADL	1.004
		4	PC1	8-10	Physical high ADL	1.019
		5	PD1	11-28	Physical very-high ADL	1.418





## Documentation errors vs. Payment errors

- A Payment error counts towards the final “error rate” presented at the time of the exit interview.
- A Documentation or clinical error does not count towards the final error rate.
- Both types of errors must be corrected





Providers must use the **MDS-RCA Correction Form** to request correction of erroneous data that has already been submitted.

2 types of corrections:

- Modification
- Inactivation





# **MDS-RCA Assessment Tool**

## **Section by Section**





# Section AA: Identification Information.

1.	<b>RESIDENT NAME</b>				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	<b>GENDER</b>	<input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female			
3.	<b>BIRTHDATE</b>	<div> <div> <div></div> <div></div> </div> <div>—</div> <div> <div></div> <div></div> </div> <div>—</div> <div> <div></div> <div></div> <div></div> <div></div> </div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>			
4.	<b>RACE/ETHNICITY</b> <i>(Check only one.)</i>	<div> <input type="checkbox"/> 1. American Indian/Alaskan Native                     <input type="checkbox"/> 4. Hispanic                 </div> <div> <input type="checkbox"/> 2. Asian/Pacific Islander                     <input type="checkbox"/> 5. White, not of Hispanic origin                 </div> <div> <input type="checkbox"/> 3. Black, not of Hispanic origin                     <input type="checkbox"/> 6. Other                 </div>			
5.	<b>SOCIAL SECURITY and MEDICARE NUMBERS</b> <i>(C in 1<sup>st</sup> box if no med. no.)</i>	<div> <b>a. Social Security Number</b>  <div> <div> <div></div> <div></div> </div> <div>—</div> <div> <div></div> <div></div> </div> <div>—</div> <div> <div></div> <div></div> <div></div> <div></div> </div> </div> </div> <div> <b>b. Medicare number (or comparable railroad insurance number)</b>  <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>—</div> <div></div> <div></div> </div> </div>			
6.	<b>FACILITY NAME AND PROVIDER NO.</b>	<div> <b>a. Facility Name</b>  <div></div> </div> <div> <b>b. Provider No.</b>  <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> </div>			
7.	<b>MAINECARE NO.</b>	<div> <i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i>  <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> </div>			
<b>8. SIGNATURE(S) OF PERSON(S) COMPLETING TRACKING FORM:</b>					
a. Signatures		Title		Sections	Date
b.					Date
c.	<b>DATE COMPLETED</b>	Record date tracking form was completed. <div> <div> <div></div> <div></div> </div> <div>—</div> <div> <div></div> <div></div> </div> <div>—</div> <div> <div></div> <div></div> <div></div> <div></div> </div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>			



Face Sheet: Background Information  
Completed at the time of the resident's  
initial admission to the facility.

Section AB: Demographic Information

Section AC: Customary Routine

Section AD: Face Sheet Signatures and  
dates



## Section A: Identification and Background information

1.	<b>RESIDENT NAME</b>	<div>a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)</div>
2.	<b>SOCIAL SECURITY and MEDICARE NUMBERS</b> (C in 1 <sup>st</sup> box if no med. no.)	<div>a. Social Security Number</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div>b. Medicare number (or comparable railroad insurance number)</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> </div>
3.	<b>FACILITY NAME AND PROVIDER NO.</b>	<div>a. Facility Name</div> <div>_____</div> <div>b. Provider No.</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>
4.	<b>MAINECARE NO.</b>	<div>(Record a "+" if pending, "N" if not a MaineCare recipient)</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>
5.	<b>ASSESSMENT DATE</b>	<div><i>Last day of observation period</i></div> <div> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div>Month                      Day                      Year</div>
6.	<b>REASON FOR ASSESSMENT</b>	<div>(Check primary reason for assessment)</div> <div> <input type="checkbox"/> 1. Admission assessment      <input type="checkbox"/> 4. Semi-Annual  <input type="checkbox"/> 2. Annual assessment      <input type="checkbox"/> 5. Other (specify)  <input type="checkbox"/> 3. Significant change in status assessment _____ </div>



## Section B: Cognitive Patterns

1.	<b>MEMORY</b>	<i>(Recall of what was learned or known)</i> a. Short-term memory OK—seems/appears to recall after 5 minutes <input type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem b. Long-term memory OK—seems/appears to recall long past <input type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem
2.	<b>MEMORY/ RECALL ABILITY</b>	<i>(Check all that resident was normally able to recall during last 7 days)</i> <input type="checkbox"/> a. Current season <input type="checkbox"/> d. That he/she is in a facility/home <input type="checkbox"/> b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled <input type="checkbox"/> c. Staff names/faces
3.	<b>COGNITIVE SKILLS FOR DAILY DECISION- MAKING</b> <i>(Check only one.)</i>	<i>(Made decisions regarding tasks of daily life)</i> <input type="checkbox"/> 0. INDEPENDENT—decisions consistent/reasonable <input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only <input type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor, cues/ supervision required <input checked="" type="checkbox"/> 3. SEVERELY IMPAIRED—never/rarely made decisions
4.	<b>COGNITIVE STATUS</b> <i>(Check only one.)</i>	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days). <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined







## SECTION C. COMMUNICATION/HEARING PATTERNS

1.	<b>HEARING</b> <i>(Check only one.)</i>	<i>(With hearing appliance, if used)</i> <input type="checkbox"/> 0. <i>HEARS ADEQUATELY</i> —normal talk, TV, phone <input type="checkbox"/> 1. <i>MINIMAL DIFFICULTY</i> when not in quiet setting <input type="checkbox"/> 2. <i>HEARS IN SPECIAL SITUATIONS ONLY</i> —speaker has to adjust tonal quality and speak distinctly <input type="checkbox"/> 3. <i>HIGHLY IMPAIRED</i> —absence of useful hearing
2.	<b>COMMUNICATION DEVICES/TECHNIQUES</b>	<i>(Check all that apply during last 7 days.)</i> <input type="checkbox"/> a. Hearing aid, present and used <input type="checkbox"/> b. Hearing aid, present and not used regularly <input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading) <input type="checkbox"/> d. <i>NONE OF ABOVE</i>
3.	<b>MAKING SELF UNDERSTOOD</b> <i>(Check only one.)</i>	<i>(Expressing information content—however able)</i> <input type="checkbox"/> 0. <i>UNDERSTOOD</i> <input type="checkbox"/> 1. <i>USUALLY UNDERSTOOD</i> —difficulty finding words or finishing thoughts <input type="checkbox"/> 2. <i>SOMETIMES UNDERSTOOD</i> —ability is limited to making concrete requests <input type="checkbox"/> 3. <i>RARELY/NEVER UNDERSTOOD</i>
4.	<b>ABILITY TO UNDERSTAND OTHERS</b> <i>(Check only one.)</i>	<i>(Understanding information content—however able)</i> <input type="checkbox"/> 0. <i>UNDERSTANDS</i> <input type="checkbox"/> 1. <i>USUALLY UNDERSTANDS</i> —may miss some part / intent of message <input type="checkbox"/> 2. <i>SOMETIMES UNDERSTANDS</i> —responds adequately to simple, direct communication <input type="checkbox"/> 3. <i>RARELY/NEVER UNDERSTANDS</i>



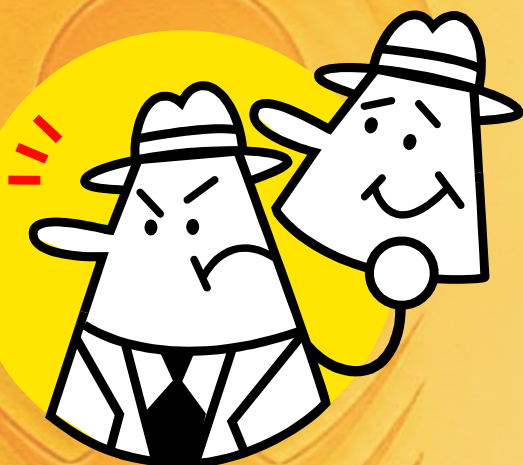


## SECTION D. VISION PATTERNS

1.	<b>VISION</b> <i>(Check only one.)</i>	<i>(Ability to see in adequate light and with glasses if used)</i> <input type="checkbox"/> 0. <i>ADEQUATE</i> —sees fine detail, including regular print in newspapers/books <input type="checkbox"/> 1. <i>IMPAIRED</i> —sees large print, but not regular print in newspapers/books <input type="checkbox"/> 2. <i>MODERATELY IMPAIRED</i> —limited vision; not able to see newspaper headlines, but can identify objects <input type="checkbox"/> 3. <i>HIGHLY IMPAIRED</i> —object identification in question, but eyes appear to follow objects <input type="checkbox"/> 4. <i>SEVERELY IMPAIRED</i> —no vision or sees only light, colors, or shapes; eyes do not appear to follow objects			
2.	<b>VISUAL APPLIANCES</b>	a. Glasses, contact lenses b. Artificial eye	<input type="checkbox"/> 0. No <input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 1. Yes	







## SECTION E. MOOD and BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<p><i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i></p> <p>0. Not exhibited in last 30 days</p> <p>1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month).</p> <p>2. This type of behavior exhibited daily or almost daily (6, 7 days/week)</p> <p><b>VERBAL EXPRESSIONS OF DISTRESS</b></p> <p>___ a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."</p> <p>___ b. Repetitive questions—e.g., "Where do I go; What do I do?"</p> <p>___ c. Repetitive verbalizations—e.g., calling out for help, ("God help me")</p> <p>___ d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received</p> <p>___ e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"</p> <p>___ f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others</p> <p>___ g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack</p> <p>___ h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions</p> <p>___ i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues</p> <p><i>(continued next page)</i></p>
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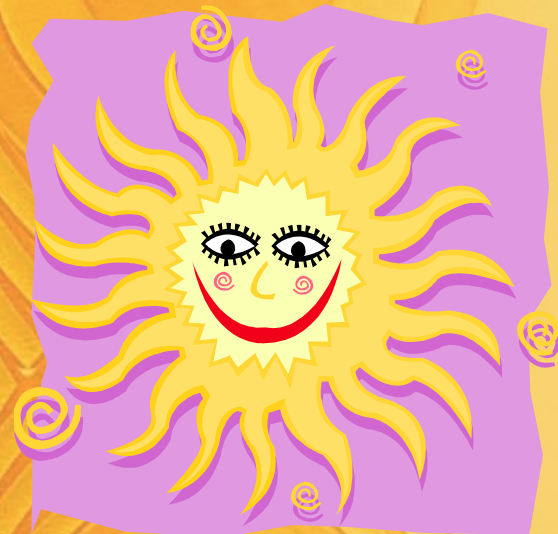


## Section E: Mood and Behavior Patterns (cont)



1.	<b>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</b>	<p><i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i></p> <ul style="list-style-type: none"> <li>0. Not exhibited in last 30 days</li> <li>1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month).</li> <li>2. This type of behavior exhibited daily or almost daily (6, 7 days/week)</li> </ul> <p><b>SLEEP-CYCLE ISSUES</b></p> <ul style="list-style-type: none"> <li>___ j. Unpleasant mood in morning</li> <li>___ k. Insomnia/change in usual sleep pattern</li> </ul> <p><b>SAD, APATHETIC, ANXIOUS APPEARANCE</b></p> <ul style="list-style-type: none"> <li>___ l. Sad, pained, worried facial expressions—e.g., furrowed brows</li> <li>___ m. Crying, tearfulness</li> <li>___ n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking</li> </ul> <p><b>LOSS OF INTEREST</b></p> <ul style="list-style-type: none"> <li>___ o. Withdrawal from activities of interest—e.g., no interest in long-standing activities or being with family/friends</li> <li>___ p. Reduced social interaction</li> </ul> <p><b>INDICATORS OF MANIA</b></p> <ul style="list-style-type: none"> <li>___ q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc.</li> <li>___ r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)</li> </ul>
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## SECTION F. PSYCHOSOCIAL WELL-BEING

1.	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b> <i>(Check all that apply.)</i>	<input type="checkbox"/> a. At ease interacting with others <input type="checkbox"/> b. At ease doing planned or structured activities <input type="checkbox"/> c. At ease doing self-initiated activities <input type="checkbox"/> d. Establishes own goals <input type="checkbox"/> e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) <input type="checkbox"/> f. Accepts invitations into most group activities <input type="checkbox"/> g. <b>NONE OF ABOVE</b>
2.	<b>UNSETTLED RELATIONSHIPS</b> <i>(Check all that apply.)</i>	<input type="checkbox"/> a. Covert/open conflict with or repeated criticism of staff <input type="checkbox"/> b. Unhappy with roommate <input type="checkbox"/> c. Unhappy with residents other than roommate <input type="checkbox"/> d. Openly expresses conflict/anger with family/friends <input type="checkbox"/> e. Absence of personal contact with family/friends <input type="checkbox"/> f. Recent loss of close family member/friend <input type="checkbox"/> g. Does not adjust easily to change in routines <input type="checkbox"/> h. <b>NONE OF ABOVE</b>
3.	<b>LIFE-EVENTS HISTORY</b> <i>(Check all that apply.)</i>	<b>Events in past 2 years</b> <input type="checkbox"/> a. Serious accident or physical illness <input type="checkbox"/> b. Health concerns for other person <input type="checkbox"/> c. Death of family member or close friend <input type="checkbox"/> d. Trouble with the law <input type="checkbox"/> e. Robbed/physically attacked <input type="checkbox"/> f. Conflict laden or severed relationship <input type="checkbox"/> g. Loss of income leading to change in lifestyle <input type="checkbox"/> h. Sexual assault/abuse <input type="checkbox"/> i. Child custody issues <input type="checkbox"/> j. Change in marital/partner status <input type="checkbox"/> k. Review hearings (e.g., forensic, certification, capacity hearing) <input type="checkbox"/> l. <b>NONE OF ABOVE</b>





## ADL SELF-PERFORMANCE

Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days.

### SECTION G. PHYSICAL FUNCTIONING

<b>1. (A) ADL SELF-PERFORMANCE</b> <b>0. INDEPENDENT</b> —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days <b>1. SUPERVISION</b> —Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days <b>2. LIMITED ASSISTANCE</b> —Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times. <b>3. EXTENSIVE ASSISTANCE</b> —While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days <b>4. TOTAL DEPENDENCE</b> —Full staff performance of activity during last 7 days <b>8. ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS</b>		
<b>(B) ADL SUPPORT CODES</b> (CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.		
	A	B
	SELF-PERFORMANCE	SUPPORT
a. <b>BED MOBILITY</b> — How resident moves to and from lying position, turns side to side, and positions body while in bed		
b. <b>TRANSFER</b> — How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c. <b>LOCOMOTION</b> — How resident moves to and returns from other locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
d. <b>DRESSING</b> — How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e. <b>EATING</b> — How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
f. <b>TOILET USE</b> — How resident uses the toilet room (or commode, bed- pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g. <b>PERSONAL HYGIENE</b> — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		





## (A) ADL SELF-PERFORMANCE

0. **INDEPENDENT**—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. **SUPERVISION**—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. **LIMITED ASSISTANCE**—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times.
3. **EXTENSIVE ASSISTANCE**—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
  - Weight-bearing support
  - Full staff performance during part (but not all) of last 7 days
4. **TOTAL DEPENDENCE**—Full staff performance of activity during last 7 days
8. **ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS**

(B) **ADL SUPPORT CODES** (CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. Activity did not occur during entire 7 days

A	B
SELF-PERFORMANCE	SUPPORT





## SECTION H. CONTINENCE IN LAST 14 DAYS

<b>1. CONTINENCE SELF-CONTROL CATEGORIES</b> (Code for resident's PERFORMANCE OVER ALL SHIFTS)																					
0. <i>CONTINENT</i> —Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)																					
1. <i>USUALLY CONTINENT</i> —BLADDER, Incontinent episodes once a week or less; BOWEL, less than weekly																					
2. <i>OCCASIONALLY INCONTINENT</i> —BLADDER, 2 or more times a week but not daily; BOWEL, once a week																					
3. <i>FREQUENTLY INCONTINENT</i> —BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week																					
4. <i>INCONTINENT</i> —Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time																					
<b>a. BOWEL CONTINENCE</b>	Control of bowel movement, with appliance or bowel continence programs, if employed																				
<b>b. BLADDER CONTINENCE</b>	Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed																				
<b>2. BOWEL ELIMINATION PATTERN</b>	<table border="1"> <tr> <td>regular—at least one movement every three days</td> <td><b>a.</b></td> <td>Diarrhea</td> <td><b>c.</b></td> </tr> <tr> <td>Constipation</td> <td><b>b.</b></td> <td>Fecal Impaction</td> <td><b>d.</b></td> </tr> <tr> <td></td> <td></td> <td>Resident is independent</td> <td><b>e.</b></td> </tr> <tr> <td></td> <td></td> <td>NONE OF ABOVE</td> <td><b>f.</b></td> </tr> </table>	regular—at least one movement every three days	<b>a.</b>	Diarrhea	<b>c.</b>	Constipation	<b>b.</b>	Fecal Impaction	<b>d.</b>			Resident is independent	<b>e.</b>			NONE OF ABOVE	<b>f.</b>				
regular—at least one movement every three days	<b>a.</b>	Diarrhea	<b>c.</b>																		
Constipation	<b>b.</b>	Fecal Impaction	<b>d.</b>																		
		Resident is independent	<b>e.</b>																		
		NONE OF ABOVE	<b>f.</b>																		
<b>3. APPLIANCES and PROGRAMS</b>	<table border="1"> <tr> <td>Any scheduled toileting plan</td> <td><b>a.</b></td> <td>Did not use toilet room/ commode/urinal</td> <td><b>f.</b></td> </tr> <tr> <td>Bladder retraining program</td> <td><b>b.</b></td> <td>Pads/briefs used</td> <td><b>g.</b></td> </tr> <tr> <td>External (condom) catheter</td> <td><b>c.</b></td> <td>Enemas/irrigation</td> <td><b>h.</b></td> </tr> <tr> <td>Indwelling catheter</td> <td><b>d.</b></td> <td>Ostomy present</td> <td><b>i.</b></td> </tr> <tr> <td>Intermittent catheter</td> <td><b>e.</b></td> <td>NONE OF ABOVE</td> <td><b>j.</b></td> </tr> </table>	Any scheduled toileting plan	<b>a.</b>	Did not use toilet room/ commode/urinal	<b>f.</b>	Bladder retraining program	<b>b.</b>	Pads/briefs used	<b>g.</b>	External (condom) catheter	<b>c.</b>	Enemas/irrigation	<b>h.</b>	Indwelling catheter	<b>d.</b>	Ostomy present	<b>i.</b>	Intermittent catheter	<b>e.</b>	NONE OF ABOVE	<b>j.</b>
Any scheduled toileting plan	<b>a.</b>	Did not use toilet room/ commode/urinal	<b>f.</b>																		
Bladder retraining program	<b>b.</b>	Pads/briefs used	<b>g.</b>																		
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Indwelling catheter	<b>d.</b>	Ostomy present	<b>i.</b>																		
Intermittent catheter	<b>e.</b>	NONE OF ABOVE	<b>j.</b>																		

Note: this section has a **14-day** look back period.



## POP QUIZ !

**0 - Continent** – Complete control

**1 - Usually Continent** – Bladder, incontinent episodes occur once a week or less. Bowel incontinent episodes occur less than once a week.

**2 - Occasionally Incontinent** – Bladder incontinent episode occur two or more times a week but not daily. Bowel incontinent episodes occur once a week.

**3 - Frequently Incontinent** – Bladder, tended to be incontinent daily, but some control present (e.g., on day shift) Bowel, 2-3 times a week.

**4 - Incontinent** – Bladder incontinent episodes occur multiple times daily. Bowel incontinence is all (or almost all) of the time.

A. Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.

B. Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet.

C. Although she is generally continent of urine, every once in a while (about once in two weeks) Mrs. T doesn't make it to the bathroom in time after receiving her daily diuretic pill

D. Late in the day when she is tired, Mrs. A sometimes (but not all days) has more episodes of urinary incontinence.



## Section I: Diagnosis



All diseases and conditions must have physician documented diagnosis in the clinical record.

Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan.

**These  
diagnoses  
contribute  
to the  
Clinically  
Complex  
RUG  
groups**

Diabetes with daily insulin injections

Aphasia

Cerebral palsy

Hemiparesis/hemiplegia

Multiple sclerosis (MS)

Quadriplegia

Explicit terminal prognosis (6 months or less)





## Section J covers Health Conditions and Possible Medication Side Effects...



A lot of territory!



- J1. Problem conditions
- J2. Extrapramidal signs and symptoms
- J3 and 4. Pain Symptoms and location
- J5 and 6. Pain interference and management
- J7. Accidents
- J8. Fall risk





## Section J. Health Conditions and Possible Medication Side Effects

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS		
1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)
		<input type="checkbox"/> a. Inability to lie flat due to shortness of breath
		<input type="checkbox"/> b. Shortness of breath
		<input type="checkbox"/> c. Edema
		<input type="checkbox"/> d. Dizziness/vertigo
		<input type="checkbox"/> e. Delusions
		<input type="checkbox"/> f. Hallucinations
		<input type="checkbox"/> g. Hostility
		<input type="checkbox"/> h. Suspiciousness
		<input type="checkbox"/> i. Headache
		<input type="checkbox"/> j. Numbness/tingling
		<input type="checkbox"/> k. Blurred vision
		<input type="checkbox"/> l. Dry mouth
		<input type="checkbox"/> m. Excessive salivation or drooling
		<input type="checkbox"/> n. Change in normal appetite
		<input type="checkbox"/> o. Other (specify) _____
		<input type="checkbox"/> p. NONE OF ABOVE



Delusions and Hallucinations are both items that can contribute to the Behavioral Health RUG groups. **Descriptive documentation required**



## Section K: Oral and Nutritional Status



## SECTION K. ORAL/NUTRITIONAL STATUS

1.	<b>ORAL PROBLEMS</b> (Check all that apply.)	<input type="checkbox"/> a. Mouth is "dry" when eating a meal <input type="checkbox"/> b. Chewing Problem <input type="checkbox"/> c. Swallowing Problem	<input type="checkbox"/> d. Mouth Pain <input type="checkbox"/> e. NONE OF ABOVE
2.	<b>HEIGHT AND WEIGHT</b>	<i>Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.</i> <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="text-align: right;">a. HT (in.)</div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="text-align: right;">b. WT (lb.)</div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> </div>	
3.	<b>WEIGHT CHANGE</b>	<p>a. Unintended weight loss—5% or more in last 30 days; or 10% or more in last 180 days</p> <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> 0. No           <input type="checkbox"/> 1. Yes         </div> <p>b. Unintended weight gain—5% or more in last 30 days; or 10% or more in last 180 days</p> <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> 0. No           <input type="checkbox"/> 1. Yes         </div>	
4.	<b>NUTRITIONAL PROBLEMS OR APPROACHES</b> (Check all that apply.)	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> a. Complains about the taste of many foods  <input type="checkbox"/> b. Regular or repetitive complaints of hunger  <input type="checkbox"/> c. Leaves 25% of food uneaten at most meals  <input type="checkbox"/> d. Therapeutic diet  <input type="checkbox"/> e. Mechanically altered (or pureed) diet           </div> <div style="width: 50%;"> <input type="checkbox"/> f. Noncompliance with diet  <input type="checkbox"/> g. Eating disorders  <input type="checkbox"/> h. Food allergies (specify) _____  <input type="checkbox"/> i. Restrictions (specify) _____  <input type="checkbox"/> j. NONE OF ABOVE           </div> </div>	





## Section L: Oral / Dental Status

### SECTION L. ORAL/DENTAL STATUS

<b>1.</b>	<b>ORAL STATUS AND DISEASE PREVENTION</b>  <i>(Check all that apply.)</i>	<ul style="list-style-type: none"><li><input type="checkbox"/> <b>a.</b> Has dentures or removable bridge</li><li><input type="checkbox"/> <b>b.</b> Some/all natural teeth lost—does not have or does not use dentures (or partial plates)</li><li><input type="checkbox"/> <b>c.</b> Broken, loose or carious teeth</li><li><input type="checkbox"/> <b>d.</b> Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes</li><li><input type="checkbox"/> <b>e.</b> Daily cleaning of teeth/dentures or daily mouth care—by resident or staff</li><li><input type="checkbox"/> <b>f.</b> Resident has difficulty brushing teeth or dentures</li><li><input type="checkbox"/> <b>g.</b> NONE OF ABOVE</li></ul>
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## Section M: Skin Condition



If **M1b** is checked, it will contribute to a clinically complex RUG group

## SECTION M. SKIN CONDITION

1.	<b>SKIN PROBLEMS</b> <i>(Check all that apply.)</i>	Any troubling skin conditions or changes in the last 7 days? <input type="checkbox"/> a. Abrasions (scrapes) or cuts <input type="checkbox"/> e. Open sores or lesions <input type="checkbox"/> b. Burns (2nd or 3rd degree) <input type="checkbox"/> f. Other (specify) <input type="checkbox"/> c. Bruises <input type="checkbox"/> d. Rashes, itchiness, body lice <input type="checkbox"/> g. <i>NONE OF ABOVE</i>								
2.	<b>ULCERS</b> <i>(Due to any cause.)</i>	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9=9 or more.) Requires full body exam. a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.								
		<table border="1"> <tr> <td data-bbox="1676 544 1767 682" style="writing-mode: vertical-rl; transform: rotate(180deg);">Number at Stage</td> <td data-bbox="1676 682 1767 753"></td> </tr> <tr> <td data-bbox="1676 753 1767 825"></td> <td data-bbox="1676 825 1767 896"></td> </tr> <tr> <td data-bbox="1676 896 1767 968"></td> <td data-bbox="1676 968 1767 1039"></td> </tr> <tr> <td data-bbox="1676 1039 1767 1110"></td> <td data-bbox="1676 1110 1767 1182"></td> </tr> </table>	Number at Stage							
Number at Stage										



## Section M: Skin Condition



If M2a, b, c, or d is coded greater than 0, this item will contribute to a clinically complex RUG group

## SECTION M. SKIN CONDITION

1.	<b>SKIN PROBLEMS</b> <i>(Check all that apply.)</i>	Any troubling skin conditions or changes in the last 7 days? <input type="checkbox"/> a. Abrasions (scrapes) or cuts <input type="checkbox"/> e. Open sores or lesions <input type="checkbox"/> b. Burns (2nd or 3rd degree) <input type="checkbox"/> f. Other (specify) _____ <input type="checkbox"/> c. Bruises <input type="checkbox"/> d. Rashes, itchiness, body lice <input type="checkbox"/> g. NONE OF ABOVE
2.	<b>ULCERS</b> <i>(Due to any cause.)</i>	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9=9 or more.) Requires full body exam. a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.
3.	<b>FOOT PROBLEMS</b>	a. Resident or someone else inspects resident's feet on a regular basis? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, enlarged toe in last 7 days? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes





## Section N: Activity Pursuit Patterns

### SECTION N. ACTIVITY PURSUIT PATTERNS

1.	<b>TIME AWAKE</b>	<i>(Check appropriate time periods over last 7 days)</i> Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: <input type="checkbox"/> a. Morning <input type="checkbox"/> d. Night (Bedtime to A.M.) <input type="checkbox"/> b. Afternoon <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Evening
2.	<b>AVERAGE TIME INVOLVED IN ACTIVITIES</b>  <i>(Check only one.)</i>	<i>(When awake and not receiving treatments or ADL care)</i> <input type="checkbox"/> 1. Most—more than 2/3 of time <input type="checkbox"/> 2. Some—from 1/3 to 2/3 of time <input type="checkbox"/> 3. Little—less than 1/3 of time <input type="checkbox"/> 4. None
3.	<b>PREFERRED ACTIVITY SETTINGS</b>	<i>(Check all settings in which activities are preferred)</i> <input type="checkbox"/> a. Own room <input type="checkbox"/> d. Away from facility <input type="checkbox"/> b. Day/activity room <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Outside facility (e.g., in yard)
4.	<b>GENERAL ACTIVITY PREFERENCES</b>	<i>(Check all PREFERENCES whether or not activity is currently available to resident)</i> <input type="checkbox"/> a. Cards/other games <input type="checkbox"/> k. Gardening or plants <input type="checkbox"/> b. Crafts/arts <input type="checkbox"/> l. Talking or conversing <input type="checkbox"/> c. Exercise/sports <input type="checkbox"/> m. Helping others







## Section O: Medications

This item can contribute to the clinically complex RUG group, *in combination with a diagnosis of Diabetes*

### SECTION O. MEDICATIONS (cont.)

4A.	<b>DAYS RECEIVED THE FOLLOWING MEDICATION</b>	(Record the number of DAYS during the last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) <div style="display: flex; justify-content: space-between;"> <div> <input type="text"/> a. Antipsychotic  <input type="text"/> b. Antianxiety  <input type="text"/> c. Antidepressant         </div> <div> <input type="text"/> d. Hypnotic  <input type="text"/> e. Diuretic  <input type="text"/> f. Aricept         </div> <div style="border: 2px solid red; padding: 2px;"> <input type="text"/> g. Insulin         </div> </div>
4B.	<b>PRN MEDICATIONS</b>	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
5.	<b>SELF-ADMINISTERED MEDICATIONS</b> <i>(Check all that apply.)</i>	Did resident self-administer any of the following in the last 7 days: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> a. Insulin  <input type="checkbox"/> b. Oxygen  <input type="checkbox"/> c. Nebulizers  <input type="checkbox"/> d. Nitropatch         </div> <div style="width: 50%;"> <input type="checkbox"/> e. Glucosan  <input type="checkbox"/> f. Over-the-counter Meds  <input type="checkbox"/> g. Other (specify) _____  <input type="checkbox"/> h. NONE OF ABOVE         </div> </div>
6.	<b>MEDICATION PREPARATION ADMINISTRATION</b>	Did resident prepare and administer his/her own medications in last 7 days? <i>(Check only one.)</i> <input type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Resident prepared and administrated <b>NONE</b> of his/her own medications. <input type="checkbox"/> 2. Resident prepared and administrated <b>SOME</b> of his/her own medications. <input type="checkbox"/> 3. Resident prepared and administrated <b>ALL</b> of his/her own medications.



## Section P: Special Treatments and Procedures



These items will contribute to the clinically complex RUG group

**SECTION P. SPECIAL TREATMENTS and PROCEDURES**

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

**a. SPECIAL CARE—Check treatments or programs received during the last 14 days [Note—count only post admission treatments]**

☐ a. Chemotherapy or radiation

☐ b. Oxygen therapy

☐ c. Dialysis

**PROGRAMS**

☐ d. Alcohol/drug treatment program

☐ e. Alzheimer's/dementia special care unit

☐ f. Hospice care

☐ g. Home health

☐ h. Home care

☐ i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)

☐ j. Case management

☐ k. Day treatment program

☐ l. Sheltered workshop/employment

☐ m. Job training

☐ n. Transportation

☐ o. Psychological rehabilitation

☐ p. Formal education

☐ q. NONE OF ABOVE

**b. THERAPIES—Record the number of days each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. a day)**

(Note—count only post admission therapies)

(A) = # of days administered for 15 minutes or more

Check B if therapy was received at home or in facility

Check C if therapy was received out-of-home or facility

	Days (A)	ON SITE (B)	OFF SITE (C)
a. Speech-language pathology and auditory services			
b. Occupational therapy			
c. Physical therapy			
d. Respiratory therapy			
e. Psychological therapy (by any licensed mental health professional)			



## Section P: Special Treatments and Procedures (cont.)

2.	<b>INTER- VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS</b>	<p><i>(Check all interventions or strategies used in the last 7 days unless other time specified—no matter where received)</i></p> <div style="border: 2px solid red; padding: 10px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> a. Special behavior symptom evaluation program  <input type="checkbox"/> b. Special behavior management program  <input type="checkbox"/> c. Evaluation by a licensed mental health specialist in last 90 days  <input type="checkbox"/> d. Group therapy  <input type="checkbox"/> e. Resident-specific deliberate changes in the                         </div> <div style="width: 45%;"> <div style="text-align: right;">environment to address mood/behavior patterns—e.g., providing bureau in which to rummage</div> <input type="checkbox"/> f. Reorientation—e.g., cueing  <input type="checkbox"/> g. Validation/Redirection  <input type="checkbox"/> h. Crisis intervention in facility  <input type="checkbox"/> i. Crisis stabilization unit in last 90 days  <input type="checkbox"/> j. Other (specify) _____  <input type="checkbox"/> k. NONE OF ABOVE                         </div> </div> </div>
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These items will contribute to a Behavioral Health RUG group if *three (3) or more* items in P2A – P2J are checked



## Section P: Special Treatments and Procedures (cont)

3.	NEED FOR ON-GOING MONITORING	(Code for person responsible for monitoring)	
		0. No monitoring required	2. RCF Other Staff
		1. RCF nurse	3. Home health nurse
		<input type="checkbox"/> a. Acute physical or psychiatric condition - not chronic	<input type="checkbox"/> b. New treatment/medication



These items will contribute to a Clinically Complex RUG group



## Section P: Special Treatments and Procedures (cont)



P4. Rehab / Restorative care

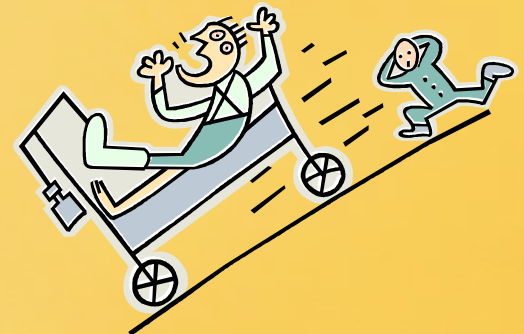
P5. Skill Training

P6. Adherence With Treatments/Therapies Programs

P7. General Hospital Stays

P8. Emergency Room (ER) Visit(s)

P9. Physician Visits





## Section P: Special Treatments and Procedures (cont)

10.	<b>PHYSICIAN ORDERS</b>	In the last 14 days (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "0" if none)		
-----	-------------------------	--	--	--

Note: Code the number of **days** the physician changed the resident's orders, not including order renewals without Change or clarification of orders.



This item will contribute to the Clinically Complex RUG group if coded as **4 or more**



## Section P: Special Treatments and Procedures (cont)



P11. Abnormal Lab Values

P12. Psychiatric Hospital Stay(s)

P13. Outpatient Surgery







## Section Q: Service Planning

### SECTION Q. SERVICE PLANNING

1.	<b>RESIDENT GOALS</b>  <i>(Check all areas in which resident has self-identified goals)</i>	<input type="checkbox"/> a. Health promotion/wellness/exercise <input type="checkbox"/> b. Social involvement/making friends <input type="checkbox"/> c. Activities/hobbies/adult learning <input type="checkbox"/> d. Rehabilitation—skilled <input type="checkbox"/> e. Maintaining physical or cognitive function <input type="checkbox"/> f. Participation in the community <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> h. No goals
2.	<b>CONFLICT</b>	<p>a. Any disagreement between resident and family about goals or service plan? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p> <p>b. Any disagreement between resident/family and staff about goals or service plan? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes</p>

Note: this item refers to  
**Resident self-identified goals**



## Section R: Discharge Potential

### SECTION R. DISCHARGE POTENTIAL

1.	<b>DISCHARGE POTENTIAL</b>	
		a. Does resident or family indicate a preference to return to community? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
		b. Does resident have a support person who is positive towards discharge? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
		c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined





## Section S: Assessment Information and Signatures



### SECTION S. ASSESSMENT INFORMATION

1.	<b>PARTICIPATION IN ASSESSMENT</b>	<p>a. Resident:      <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes</p> <p>b. Family:        <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes      <input type="checkbox"/> 2. No Family</p> <p>c. Other Non-Staff: <input type="checkbox"/> 0. No      <input type="checkbox"/> 1. Yes      <input type="checkbox"/> 2. None</p>				
2.	<p><b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b></p> <hr/> <p>a. Signature of Assessment Coordinator (sign on line above)</p> <p>b. Date Assessment Coordinator signed as complete</p> <div style="text-align: right;"> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> </div> <hr/> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">c. Other Signatures</td> <td style="width: 25%;">Title</td> <td style="width: 20%;">Sections</td> <td style="width: 5%;">Date</td> </tr> </table> <hr/> <p>d. _____ Date _____</p> <hr/> <p>e. _____ Date _____</p>		c. Other Signatures	Title	Sections	Date
c. Other Signatures	Title	Sections	Date			
3.	<b>CASE MIX GROUP</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				



## Section T: Preventive Health



### SECTION T. PREVENTIVE HEALTH/HEALTH BEHAVIORS

#### 1. PREVENTIVE HEALTH

*(Check all the procedures the resident received during the past 12 months)*

- |   |  |
|---|--|
| <input type="checkbox"/> a. Blood pressure monitoring       | <input type="checkbox"/> g. Breast exam or mammogram |
| <input type="checkbox"/> b. Hearing assessment              | <input type="checkbox"/> h. Pap smear                |
| <input type="checkbox"/> c. Vision test                     | <input type="checkbox"/> i. PSA or rectal exam       |
| <input type="checkbox"/> d. Dental visit                    | <input type="checkbox"/> j. Other (specify) _____    |
| <input type="checkbox"/> e. Influenza vaccine               |  |
| <input type="checkbox"/> f. Pneumococcal vaccine (ANY time) |  |

**Note: 12 month look back period** for preventive health measures.







## DISCHARGE FORM

### SECTION D1. IDENTIFICATION INFORMATION

1.	<b>RESIDENT NAME</b>				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	<b>GENDER</b>	<input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female			
3.	<b>BIRTHDATE</b>	<div> <div><input type="text"/></div> <div><input type="text"/></div> <div>—</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>—</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> <div>                     Month                     Day                     Year                 </div>			
4.	<b>RACE/ETHNICITY</b> (Check only one.)	<div> <input type="checkbox"/> 1. American Indian/Alaskan Native                             <input type="checkbox"/> 5. White, not of Hispanic origin                         </div> <div> <input type="checkbox"/> 2. Asian/Pacific Islander                             <input type="checkbox"/> 6. Other                         </div> <div> <input type="checkbox"/> 3. Black, not of Hispanic origin                         </div> <div> <input type="checkbox"/> 4. Hispanic                         </div>			
5.	<b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> (C in 1 <sup>st</sup> box if no med. no.)	<div>                     a. Social Security Number                     <div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div>—</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>—</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> </div> <div>                     b. Medicare number (or comparable railroad insurance number)                     <div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> </div>			
6.	<b>FACILITY NAME AND PROVIDER NO.</b>	a. Facility Name <div> <input type="text"/> </div>			

### SECTION D3. ASSESSMENT/DISCHARGE INFORMATION

1.	<b>DISCHARGE STATUS</b>	<i>Code for resident disposition upon discharge</i> <ol style="list-style-type: none"> <li>1. Private home/apt. with no home health services</li> <li>2. Private home/apt. with home health services</li> <li>3. Another residential care facility (specify) _____</li> <li>4. Nursing home (specify) _____</li> <li>5. Acute care hospital</li> <li>6. Psychiatric hospital, MR/DD facility</li> <li>7. Rehabilitation hospital</li> <li>8. Deceased</li> <li>9. Other (specify) _____</li> </ol>
2.	<b>DISCHARGE DATE</b>	<i>Date of death or discharge</i> <div> <div><input type="text"/></div> <div><input type="text"/></div> <div>—</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>—</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> <div>                     Month                     Day                     Year                 </div>
3.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b>	
	a. Signatures	<div> <div>Title</div> <div>Date</div> </div>
	b.	<div> <div>Date</div> </div>
	c.	<div> <div>Date</div> </div>



## Correction Request Form

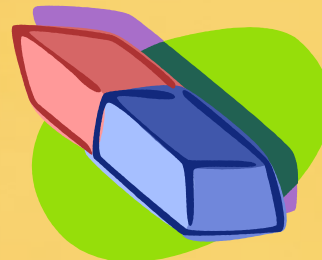


Purpose of this form:

To request correction of errors in an assessment or tracking form that has already been accepted into the database.

- To modify a record in the database
- To inactivate a record in the database

It is important that the information in the State database be correct.



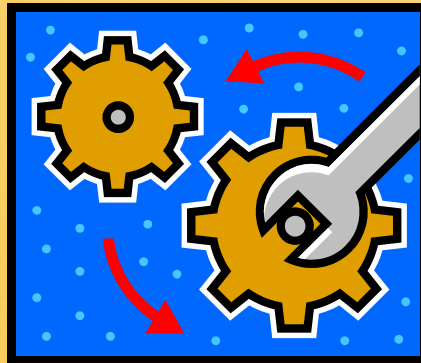


## MDS-RCA Records in Error Not Accepted into the State database

Since none of these records have been accepted into the state database, appropriate corrections can be made, and these records can simply be transmitted without any special correction procedures



If the Case Mix Nurse is unable to verify the Case Mix Group for any record reviewed, the nurse will *require* the provider to complete and submit a *corrected record*.

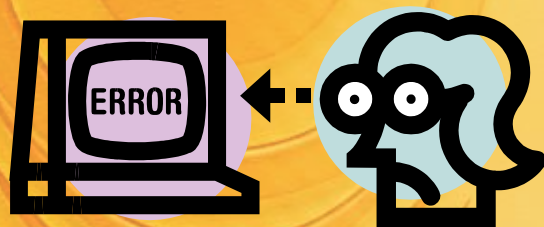




# Correction Request Form: Prior Record Section

Prior AA1	RESIDENT NAME					
		a.(First)	b.(Middle Initial)	c.(Last)	d.(Jr/Sr)	
Prior AA2	GENDER	1. Male    2. Female				
Prior AA3	BIRTHDATE	<input type="text"/> <input type="text"/>	—	<input type="text"/> <input type="text"/>	—	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		Month		Day		Year
Prior AA5a	SOCIAL SECURITY	a. Social Security Number				
		<input type="text"/> <input type="text"/> <input type="text"/>	—	<input type="text"/> <input type="text"/>	—	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Prior A6 OR D1.8	REASON FOR ASSESSMENT	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment				
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7				
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month                      Day                      Year				
Prior D3.2	DISCHARGE DATE	Date of Discharge <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month                      Day                      Year				





## Correction Request Form: Correction Section

### CORRECTION SECTION: COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	<b>CORRECTION SEQUENCE NUMBER</b>	(Enter total number of corrections for this record, including the present one.)	
AT2.	<b>ACTION REQUESTED</b>	<p>1. <b>MODIFY</b> record in error (Attach and submit a <b>COMPLETE</b> assessment or tracking form. Do <b>NOT</b> submit the corrected items <b>ONLY</b>. Proceed to item AT3 below).</p> <p>2. <b>INACTIVATE</b> record in error. (Do <b>NOT</b> submit an assessment or tracking form. Submit the correction request only. Skip to item AT4).</p>	
AT3.	<b>REASONS FOR MODIFICATION</b>	<p>(If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5)</p> <p>a. Transcription error</p> <p>b. Data entry error</p> <p>c. Software product error</p> <p>d. Item coding error</p> <p>e. Other error</p> <p>If "Other" checked, please specify:</p> <p>_____</p> <p>_____</p>	<p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p> <p>e.</p>
AT4.	<b>REASONS FOR INACTIVATION</b>	<p>(If AT2=2, check at least one of the following reasons; check all that apply.)</p> <p>a. Test record submitted as production record</p> <p>b. Event did not occur</p> <p>c. Inadvertent submission of non-required record</p> <p>d. Other reason requiring inactivation</p> <p>If "Other" checked, please specify:</p> <p>_____</p> <p>_____</p>	<p>a.</p> <p>b.</p> <p>c.</p> <p>d.</p>



## Correction Request Form

A correction request can be made to either MODIFY or INACTIVATE a record

### **TO MODIFY A RECORD IN THE STATE DATABASE**

1. Complete a corrected assessment or tracking form. Include ALL items on the form, not just those needing correction.
2. Complete the Correction Request Form and attach to the corrected assessment or tracking form
3. Place a hard copy of the complete document in the Clinical record
4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form
5. Electronically submit the new record





## Correction Request Form

To **INACTIVATE** a record in the State database

1. Complete this correction request form
2. Create an electronic record of the form
3. Place a hard copy of the documents in the Clinical record
4. Electronically submit this request.



The link to the SMS website can be found on the Muskie School of Public Service, Minimum Data Set (MDS) Technical Information website:

**<http://muskie.usm.maine.edu/mds/>**

Click on the link and the SMS log-in screen will appear. Type in your username and password and hit the Log In button to enter the site.



## Minimum Data Set (MDS) Technical Information

### Welcome to Maine's Minimum Data Set (MDS) Technical Information Site

This site provides technical information related to the family of MDS resident assessment instruments used by MaineCare (Maine's Medicaid program). The University of Southern Maine (USM) Muskie School of Public Service (MSPS) maintains this site on behalf of the Maine Department of Health and Human Services (DHHS).

The family of MDS resident assessment instruments includes Minimum Data Sets for:

- nursing facilities (MDS 3.0);
- residential care facilities (MDS-RCA); and
- adult family care homes (residential care level III).

The information stored at this site is intended to assist:

1. State and Provider staffs with the most current MDS information and resources
2. Computer software designers in meeting State requirements concerning the encoding and electronic transmission of MDS assessments

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### Website Contents List

[Nursing Home Links](#)

[Residential Care \(Level IV\) Links](#)

[Adult Family Care Homes \(Residential Care - Level III\) Links](#)

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### Nursing Home Links

MDS 3.0:

- [MDS 3.0 Website](#)

NF RUG Groupers:

- [Maine MDS RUGIII Codes](#)
- 

### Residential Care Facility Links

SMS: Maine MDS Submission Management System

- [Go to Log-in Page](#)

MDS-RCA Form:

### Project Staff

[Catherine Gunn](#)

Health Data Resources Coordinator  
Cutler Institute for Health and Social Policy  
Muskie School of Public Service

Phone: (207) 780-5576

Fax: (207) 228-8083

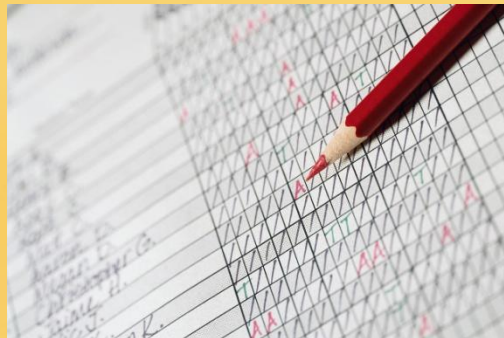
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### Suggested Audiences:

- Residential Care Facilities
  - Adult Family Care Homes
  - Nursing Facility providers
  - State agencies
  - Software programmers
-



# Documentation Requirements





# Clinically Complex

MDS RCA item and reference	Field	Documentation Requirement
<b>Clinically Complex</b>		
I1a and O4Ag pg. 69 and 90	Diabetes receiving daily insulin injections	<ul style="list-style-type: none"> <li>Physician's diagnosis of diabetes, <b>and</b></li> <li>receiving daily injections of insulin</li> </ul>
I1r, pg 64	Aphasia	<p>Definition: A speech or language disorder caused by disease or injury <u>to the brain</u> resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.</p> <p>Documentation requirements:</p> <ul style="list-style-type: none"> <li>difficulty must be noted in the resident chart</li> <li>physician's diagnosis in the record</li> <li>Current diagnosis and active treatment</li> </ul>
I1s pg. 69	Cerebral Palsy	<ul style="list-style-type: none"> <li>physician's diagnosis</li> <li>Current diagnosis and active treatment</li> </ul>
I1v	Hemiplegia/Hemiparesis	<ul style="list-style-type: none"> <li>physician's diagnosis</li> <li>Current diagnosis and active treatment</li> </ul>



## MDS-RCA Training: Documentation Requirements (Clinically Complex)

I1w	Multiple Sclerosis	<ul style="list-style-type: none"> <li>physician's diagnosis</li> <li>Current diagnosis and active treatment</li> </ul>
I1ww	Explicit Terminal Prognosis	<ul style="list-style-type: none"> <li>A physician has put in the record that the resident is terminally ill and expected to have no more than 6 months to live.</li> <li>This should be substantiated with a documentation of diagnosis and deteriorating clinical condition</li> </ul>
I1z	Quadriplegia	<ul style="list-style-type: none"> <li>A physician diagnosis of paralysis of all four limbs.</li> <li>Current diagnosis and active treatment</li> </ul>
M1b	Burns – 2 <sup>nd</sup> or 3 <sup>rd</sup> degree	<ul style="list-style-type: none"> <li>Confirmation of the degree of the burn by the physician. In accordance with the Maine State Board of Nursing, the determination of degree of a burn must be documented by a physician.</li> <li>The status of a burn can be documented by a registered nurse or physician.</li> <li>Current diagnosis and active treatment</li> </ul>
M2	Ulcers	<p>Ulcers must be staged by a registered nurse or physician, during the observation period for the MDS-RCA.</p> <ul style="list-style-type: none"> <li>Current diagnosis and active treatment</li> <li>Periodic evaluation by a Registered Nurse.</li> </ul> <p>Note: the definition of "ulcer" due to any cause means any lesion caused by pressure or decreased blood resulting in damage to underlying tissue.</p>
P1aa	Chemotherapy	<ul style="list-style-type: none"> <li>Any type of anti-cancer drug given by any route.</li> <li>Evidence in the resident record.</li> </ul> <p>Chemotherapy can only be coded if administered for a diagnosis of cancer.</p>
P1aa	Radiation	<ul style="list-style-type: none"> <li>Radiation therapy or implant.</li> <li>Evidence in the resident record.</li> </ul> <p>Radiation therapy can only be coded if administered for a diagnosis of cancer.</p>
P1ab	Oxygen	<ul style="list-style-type: none"> <li>physician's order</li> <li>administered during the past 14 days.</li> </ul>



## MDS-RCA Training: Documentation Requirements (Clinically Complex)

MDS RCA item	Field	Documentation Requirement
P1bdA	Respiratory Therapy 5 or more days per week	<ul style="list-style-type: none"> <li>Physician order</li> <li>Performed by a qualified therapist.</li> <li>Documentation of frequency, and the</li> <li>Qualified professional must be with resident at least 15 minutes per day <b>and</b> at least 5 days per week.</li> </ul> <p>Includes only therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.</p>
P3	Need for on-going monitoring	<ul style="list-style-type: none"> <li>The need for monitoring must be determined, directed and documented by a physician or a registered nurse.</li> <li>The need for on-going monitoring for:                             <ul style="list-style-type: none"> <li>An acute condition,</li> <li>A chronic condition that exacerbated into an acute episode</li> <li>A new treatment or medication</li> </ul> </li> <li>Documentation that monitoring has been provided by the person responsible within the look back period.</li> </ul>
P10	4 or more order change days	<ul style="list-style-type: none"> <li>Code the <b>number of days</b> on which physician orders were changed.</li> <li>Written, telephone, fax, or consultation orders for new or altered treatment.</li> <li>Does NOT include admission orders, return admission orders, clarifying, or renewal orders without changes.</li> </ul>



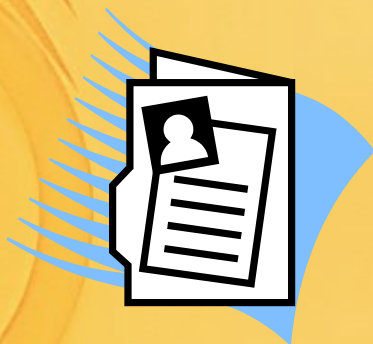
# Impaired Cognition and Problem Behavior

MDS RCA item and reference	Field	Documentation Requirement
<b>Impaired Cognition</b>		
B3, pg 29	Cognitive Skills for Daily Decision Making	Documentation of the resident's <i>actual</i> performance in making everyday decisions about tasks or activities of daily living within the look back period. Documentation must support the coding selected.
MDS RCA item	Field	Documentation Requirement
<b>Problem Behavior and Conditions</b>		
E1a-E1r, pg 34	Indicators of Depression	Evidence and observation of the identified indicators must be present in the resident record within the look back period.
J1e, pg 68	Delusions	Documentation in the resident record should describe examples of <i>fixed, false beliefs, not shared by others even when there is obvious proof or evidence to the contrary</i> , that occurred within the look back period.
J1f, pg 68	Hallucinations	Documentation in the resident record should describe examples of <i>tactile, auditory, visual, gustatory, olfactory false perceptions in the absence of any real stimuli</i> that occurred within the look back period.
P2a – P2j	Intervention Programs for Mood, Behavior, Cognitive Loss	Documentation that the resident has received any intervention and/or strategies in the last seven days. Service plan should include the evaluation for and the provision of these services as well as the outcomes of treatment.



# Physical Impairment

MDS RCA item	Field	Documentation Requirement
Physical		
G1aA	Bed mobility	Documentation in the record must reflect the resident's ADL self-performance over the 7 day period, 24 hours per day. Only self-performance counts towards the ADL score.
G1bA	Transfer	
G1cA	Locomotion	
G1dA	Dressing	
G1eA	Eating	
G1fA	Toilet Use	
G1gA	Personal Hygiene	





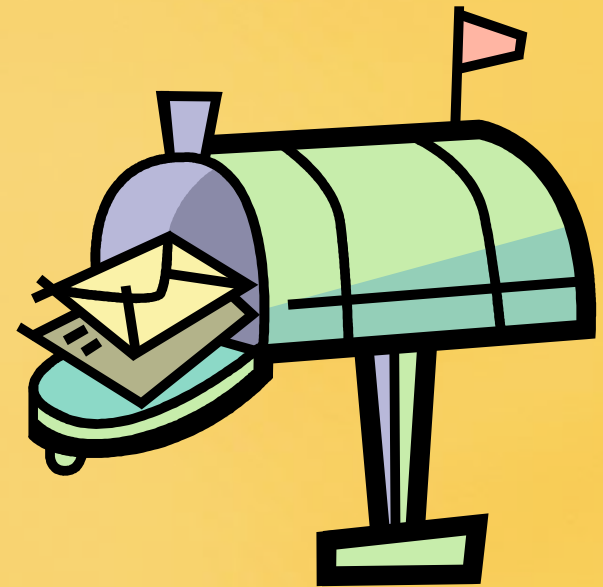
### What are Quality Indicators??

- Identify flags
- Identify exemplary care
- Identify potential care problems
- Identify residents for review
- Provide general information
- Identify education needs
- Based solely from responses on the MDS-RCA



# Quality Indicator Reports

The “PNMI Residential Care Facility Quality Indicator” report is prepared & mailed to each facility every 6 months.





## MDS-RCA Training: Quality Indicators

QI 1	Prevalence of Bladder Incontinence (High Degree of Incontinence)	QI 20	Incidence of Decline in Late Loss ADLs - Low Risk
QI 2	Prevalence of Bladder Incontinence (Low Degree of Incontinence)	QI 21	Incidence of Decline in Early Loss ADLs
QI 3	Prevalence of Bowel Incontinence (High Degree of Incontinence)	QI 22	Incidence of Decline in Early Loss ADLs - High Risk
QI 4	Prevalence of Bladder Incontinence without Scheduled Toileting Plan	QI 23	Incidence of Decline in Early Loss ADLs - Low Risk
QI 5	Prevalence of Injury	QI 24	Incidence of Improvement in Late Loss ADLs
QI 6	Prevalence of Falls	QI 25	Incidence of Improvement in Early Loss ADLs
QI 7	Prevalence of Behavioral Symptoms	QI 26	Prevalence of Emergency Room Visits without Overnight Stay
QI 8	Prevalence of Behavioral Symptoms without Behavior Management Program	QI 27	Prevalence of Psychiatric Hospital Stays in last 6 months
QI 9	Prevalence of Resident using 9 or more Medications in last 7 days including PRNs	QI 28	Prevalence of Hospital Stays in last 6 months
QI 10	Prevalence of Resident using 9 or more Scheduled Medications in last 7 days	QI 29	Prevalence of Weight Loss
QI 11	Prevalence of Cognitive Impairment	QI 30	Prevalence of Wheelchair as Primary Mode of Locomotion
QI 12	Prevalence of Modified Long Term Cognitive Impairment	QI 31	Prevalence of High Case Mix Index
QI 13	Prevalence of Little or No Activity	QI 32	Prevalence of Pain
QI 14	Prevalence of Anti-Psychotic Drugs	QI 33	Prevalence of Pain Interfering without Pain Management
QI 15	Prevalence of Awake at Night	QI 34	Prevalence of Anti-Psychotic use in Absence of Diagnosis
QI 16	Prevalence of Communication Difficulties	QI 35	Prevalence of Ulcers due to Any Cause
QI 17	Prevalence of Signs of Distress or Sad/Anxious Mood	QI 36	Prevalence of Fecal Impaction
QI 18	Incidence of Decline in Late Loss ADLs		
QI 19	Incidence of Decline in Late Loss ADLs - High Risk		



## MDS-RCA Training: Quality Indicators

Facility Name: TEST FACILITY				Facility Internal Id: 99999										Facility MaineCare Number: 999999999																															
Resident Name	Effective	Quality Indicator Number:																																											
	Date	A6	Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	Total					
Last Name, First Name	2/8/2012	Adm	89		✓				✓	✓	✓	✓	✓	✓	✓		✓			✓									✓						✓	✓		✓						14	
Last Name, First Name	4/8/2012	Adm	78	✓			✓		✓	✓	✓	✓	✓	✓	✓		✓		✓										✓	✓							✓							14	
Last Name, First Name	12/27/2011	Sem	86	✓			✓	✓				✓	✓	✓	✓									✓		✓									✓								10		
Last Name, First Name	5/7/2012	Sem	81									✓	✓	✓	✓																												4		
Last Name, First Name	10/23/2011	Sem	80						✓	✓			✓	✓	✓				✓	✓																								7	
Last Name, First Name	12/24/2011	Sem	92						✓	✓	✓	✓	✓	✓	✓	✓								✓		✓																		9	
Last Name, First Name	4/30/2012	Ann	84	✓			✓		✓			✓	✓	✓	✓				✓								✓																	9	
Last Name, First Name	11/23/2011	Ann	90	✓		✓	✓					✓	✓	✓	✓				✓						✓	✓										✓								11	
Last Name, First Name	1/7/2012	Sem	82		✓			✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓		✓	✓	✓	✓																		15	
Last Name, First Name	1/5/2012	Sig	69						✓	✓			✓	✓	✓				✓	✓										✓														8	
Last Name, First Name	3/7/2012	Ann	64	✓			✓		✓	✓		✓	✓		✓			✓																	✓			✓						11	
Last Name, First Name	12/29/2011	Sem	91										✓	✓																														2	
Last Name, First Name	4/19/2012	Sem	96	✓		✓	✓		✓	✓			✓	✓		✓			✓																✓			✓						11	
Last Name, First Name	5/13/2012	Adm	85										✓	✓																														2	
Last Name, First Name	2/18/2012	Sem	85		✓				✓	✓	✓	✓	✓	✓	✓	✓																													8
Facility Total:				6	3	2	6	2	7	9	7	10	10	14	15	4	4	0	4	7	1	0	1	4	1	3	1	0	2	2	0	0	0	0	0	5	1	0	4	0	0		135		



# Quality Indicator Terminology

**Numerator**- Describes all residents in a group with a specific trait.

**Denominator**- All residents considered for that group.

**Prevalence**- The status of a resident at a point in time (as of the current assessment.)














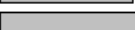
























**Incidence**- The change in status of a resident over a period of time (from the previous assessment to the current assessment.)

**Percentage**- The number of residents that actually have a QI (numerator) divided by the number that could have a QI (denominator)

**The list of the individual Quality Indicators with definitions is called the “Matrix”**



# MDS-RCA Training: Quality Indicators

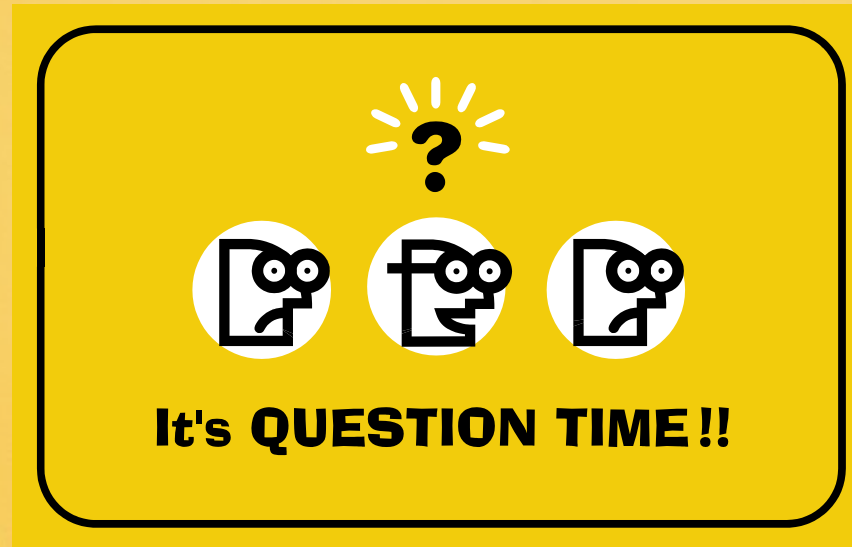
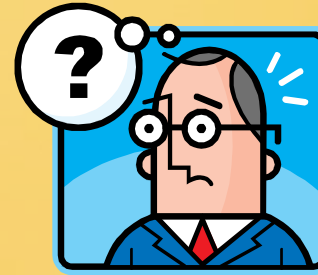
TEST FACILITY	Resident Count:		15		State Count:		3870		Percentile Rank.
	Den. [1]	Num.			Den.	Num.			
1: Prevalence of Bladder Incontinence (High):	15	6		40.0%	3820	1369		35.8%	56
2: Prevalence of Bladder Incontinence (Low):	15	3		20.0%	3820	920		24.1%	47
3: Prevalence of Bowel Incontinence (High):	15	2		26.7%	3825	297		7.8%	77
4: Prevalence of Bladder Incontinence without Scheduled Toileting Plan:	6	6		100.0%	1963	1167		59.4%	72
5: Prevalence of Injury:	15	2		13.3%	3870	185		4.8%	89 
6: Prevalence of Falls:	15	7		46.7%	3870	1429		36.9%	77
7: Prevalence of Behavioral Symptoms	15	9		60.0%	3870	1617		41.8%	66
8: Prevalence of Behavioral Symptoms without Behavior Management Program.	9	7		77.8%	1617	430		26.6%	81
9: Prevalence of Resident using 9 or more Medications in last 7 days including PRNs	15	10		66.7%	3870	2740		70.8%	0
10: Prevalence of Resident using 9 or more Scheduled Medications in last 7 days	15	10		66.7%	3870	2642		68.3%	40
11: Prevalence of Cognitive Impairment:	15	14		93.3%	3866	1539		39.8%	92 
12: Prevalence of Modified Long Term Cognitive Impairment:	15	15		100.0%	3866	2758		71.3%	79
13: Prevalence of Little or No Activity:	15	4		26.7%	3867	1100		28.4%	54
14: Prevalence of Anti-Psychotic drugs:	15	4		26.7%	1963	1030		52.5%	55
15: Prevalence of Awake at Night	15	0		0.0%	3870	167		4.3%	0
16: Prevalence of Communication Difficulties:	15	4		26.7%	3870	718		18.6%	70
17: Prevalence of Signs of Distress or Sad/Anxious Mood	15	7		46.7%	3870	2265		58.5%	35
18: Incidence of Decline in Late Loss ADLs	12	1		8.3%	1617	660		40.8%	22
19: High Risk	3	0		0.0%	3870	192		5.0%	0



## The QI Report

- Allows each facility review the results and compare your facility's percentage to the state average.
- What could cause your facility to be higher or lower than other facilities?
- Verify that the resident's condition was accurately assessed at the time the MDS-RCA was completed
- Identify if facility changes are needed









Reminders:

Quarterly Res Care Forum Calls in March,  
June, September, and December

ASK questions!

ASK more questions!

Attend training as needed



## Contact Information

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